Dr. Torres

IN THE CIRCUIT COURT FOR THE 11TH JUDICIAL CIRCUIT IN AND FOR DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

Case No. 00-01706 CA 22

LYNN FRENCH,
Plaintiff,
vs.
PHILIP MORRIS INCORPORATED,
("PHILIP MORRIS U.S.A.")
R.J. REYNOLDS TOBACCO COMPANY,
LORILLARD TOBACCO CO., and
BROWN & WILLIAMSON TOBACCO
CORP., Individually and as Successor
to the AMERICAN TOBACCO COMPANY,
Defendants.
----------x

PROCEEDINGS BEFORE
THE HONORABLE FREDRICKA SMITH

VOLUME 11

Wednesday, June 12, 2002
9:30 to 12:00 p.m.

73 West Flagler Street
Courtroom 6-2
Miami, Florida 33130

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

Thereupon,

The following proceedings were had:

THE COURT: I think the jurors have been here. They have been very prompt. They are always here on time and they are ready to start if you are ready to start.

Do you have the video?

MS. WEINSTEIN: Judge, up to the part that we did prior to yesterday, that is ready, and the Defendants can look at it, and we can play it.

The problem is that apparently what we designated yesterday afternoon hasn't been finished and will be ready by noon.

THE COURT: What are we doing now?

MS. WEINSTEIN: We would like to play it and go on with the first witness and ask the court's permission to let us play it in the afternoon.

It is very difficult to get the designations done and the video popped out and play it.

THE COURT: What is it that you want to do?

MS. WEINSTEIN: I guess proceed.

MR. TROP: Maybe take a witness out of turn. They have their doctor here. We want to read a couple of interrogatories also, but because of this, this technology, we don't have the video ready.

THE COURT: Are you ready to go with your witness?

MR. REILLY: We think they should put on their case and rest.

THE COURT: They should, but I don't want to waste hours in the morning. If you have a witness here, I would appreciate it. I will explain to the jury that you are accommodating them by going forward with your case.

Dr. Torres is here?

MR. REILLY: He is here, your Honor.

THE COURT: Why don't we do that if he is here; otherwise, it is a waste of several hours.

MR. ENGRAM: Your Honor, point of order, if they haven't rested, but we have begun our case, when do we make a Motion for Directed Verdict; at the close of their case or before we put Dr. Torres on?

THE COURT: I will consider it timely

whenever you make it. By agreeing to have Dr. Torres out of turn, you are not waiving anything.

MR. REILLY: If that is your plan, your Honor, I would suggest that they do whatever it is they will try to do --

THE COURT: Aside from --

MR. REILLY: -- aside from Dr. Richmond, and that's the last thing they get to do.

THE COURT: I think we should do it so we will be finished.

Do you want to read some interrogatories?

MS. WEINSTEIN: We have a couple of more exhibits. I don't know what number it is on your list.

THE COURT: A couple of more exhibits you are offering?

MS. WEINSTEIN: Right.

MR. REILLY: There is another matter. Probably you saw the paper this morning.

MS. WEINSTEIN: It is Plaintiff's 1-L, like Larry.

THE COURT: What would you like to do in regard to the newspaper article? What is it that you would like to do?

MR. REILLY: Your Honor, obviously there was a large verdict yesterday in another courtroom in the courthouse in a totally unrelated piece of litigation, but it did happen to relate to the tobacco industry and some of the Defendants in this lawsuit, and I am concerned that if a juror has read that, they may think that that lawsuit, in some way, is connected with this lawsuit, which clearly it is not.

THE COURT: What are you suggesting?

MR. REILLY: I think it might be advisable for your Honor to indicate that to this jury that regardless of what they may have read in the paper, if they read anything in the paper about another lawsuit --

THE COURT: If I tell them about it, they will read it if they haven't read it yet.

MR. REILLY: It's front page news of the paper. I can't help but think that some of them at least read it.

THE COURT: I think that is perhaps likely, so you would like me to make reference to it and to advise them that that case is totally unrelated to this case and they should

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

not take it into account in any way?
MR. REILLY: Right.
MR. WEINSTEIN: I object to anything being said to this jury, Judge. First of all, it's not unrelated. It involves tobacco smoke, so -- but by --
THE COURT: I think it would be really improper not to say something under the circumstances, and it is totally unrelated to this case. It has nothing to do with this case.
MR. WEINSTEIN: Judge, we have had testimony in this case that tobacco smoke is tobacco smoke whether it is --
THE COURT: Over your objection, I am going to give the instruction as requested by the Defendant.
If you have the article, you might want to just mark it as a court exhibit.
MR. REILLY: I didn't bring it, your Honor. I didn't bring it. I am sure we can get it, but I didn't bring it.
Your Honor, just so I've made an objection on the record, I object formally going forward with our case in chief before

the Plaintiffs have rested.
I understand your Honor's ruling.
THE COURT: If there was any particular prejudice or objection, I would hear you, but if it is just that they haven't rested, I don't see how you are prejudiced by it.
MR. REILLY: Also, I understand that the Plaintiffs intend to read some things to the jury.
We haven't been shown what those things are.
MS. WEINSTEIN: No, I think there was a misunderstanding. We are just going to put into evidence some interrogatory responses from the Defendants.
THE COURT: You will not publish them to the jury?
MR. WEINSTEIN: Well, you know what it is, Judge, this is like we asked them what cigarettes they manufacture, and it is all of the cigarettes named.
MS. WEINSTEIN: It is by constituents.
MR. WEINSTEIN: This is responses contained in the second motion that smoke --
THE COURT: I asked if you want to

publish it to the jury.
MR. WEINSTEIN: Well, Judge, it is 4,000 chemicals.
THE COURT: Mr. Weinstein, I am asking if you want to publish it. If you don't want to --
MR. WEINSTEIN: I want to place it into evidence.
THE COURT: Okay. Is there any objection?
MR. REILLY: Sure. Your Honor, you have repeatedly ruled that they can't simply recite a bunch of chemicals. We haven't even seen this yet, so this will be the first time I have seen this.
THE COURT: Let's identify what it is.
MS. WEINSTEIN: This is --
MR. REILLY: I don't know what you are trying to put into evidence.
MS. WEINSTEIN: R.J. Reynolds Tobacco Company's response to Plaintiff's Second Set of Interrogatories to Defendant R.J. Reynolds Company filed in the case of Anita Leon versus Philip Morris, et al.
THE COURT: Wait. It is a different

case?
MS. WEINSTEIN: Yes.
MR. REILLY: Not only is it a different case --
MS. WEINSTEIN: If I can finish or complete my sentence.
Also filed in the case of Jet versus Philip Morris. These responses to Plaintiff's interrogatories were filed in the Jet case.
The Jet case has been designated by order of Judge Simons to be the case in which it is sort of a master case. Any pleadings filed in the Jet case are to be deemed filed in any of the flight attendant cases to avoid filings of two inches thick in all 3,000 cases, so we filed it in the Jet case as well.
MR. REILLY: Your Honor, these interrogatories have extensive --
THE COURT: Can I see it?
MR. REILLY: I only looked at the first one. These interrogatories have extensive objections to them which have never been ruled on, and I would object to putting these interrogatories into evidence.
They are in different cases, number one,

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

but, number two, and perhaps far more importantly, the objections have never been ruled on.

I've never seen anybody put in Answers to Interrogatories where there have not been rulings on objections or a determination of relevance to this litigation, and your Honor has repeatedly indicated that simply naming off a bunch of constituents of cigarette smoke, unless the Plaintiffs can tie them up in some fashion to sinusitis or the causation of sinusitis, that you haven't permitted it to occur.

THE COURT: Well, I would have to look at these. If there are objections that haven't been ruled on, I think that's a problem.

There are handwritten notes on here also that is a problem, but aside from that, I mean, if there are objections, how can you just offer these? I don't think so. I think they have to be ruled on.

I don't know that I can rule on them at this time. They are quite lengthy. I think you should have brought it up prior to trial.

If there is a particular one that hasn't

been objected to that's relevant, I would consider allowing you to publish it by reading it, but not putting it into evidence with all of the other case names and numbers on them.

MS. WEINSTEIN: We would only ask that the one they answered -- you can see pages and pages of objections, but they did -- R.J. Reynolds did answer one of them by providing a document that contains a list of constituents of tobacco smoke.

THE COURT: Is this it?

MS. WEINSTEIN: Yes.

THE COURT: Which was answered without an objection?

MR. REILLY: There are none, your Honor, that have been answered without objection, and what counsel is doing is basically penalizing us for doing the good thing, which is we object, but then we provide a response.

THE COURT: If there are any that have not been objected to, I will consider it.

If all of them have been objected to, I will not allow them to produce it into evidence without having some discussion on it.

MR. WEINSTEIN: Judge, as a matter of

procedure, if somebody objects, is it -- do -- and they answer, is it our duty to say, Judge, rule on the objections or their duty? They made the objections.

THE COURT: Then I don't think they had any idea you were offering this.

MR. WEINSTEIN: We listed it.

MS. WEINSTEIN: It was listed on the exhibit list.

MR. REILLY: It might be listed, your Honor, but the time for objecting to these documents is at this time, and we are objecting to them.

We have objected to them, and we continue to object to them. We objected to them in the Leon case. We objected to them in this case.

There is no other time to object other than now, and Plaintiff's counsel has never sought a ruling on the objections until now, and I've never seen anybody be able to publish objected to interrogatories or have I ever seen anybody publish simply interrogatories.

THE COURT: Well, you can publish interrogatories.

MR. REILLY: But, in addition to that,

these are the very topic that you previously ruled, your Honor, that they cannot do it even if we haven't raised objections.

MR. ENGRAM: Your Honor, Mr. Weinstein said this is a list of 4,000 constituents in tobacco smoke.

I think the record will show from Mr. Ogden's testimony that that relates to constituents measured in mainstream smoke, because I know that Mr. Ogden's testimony is that they've not been able to measure more than I think it is 1,200 constituents in environmental tobacco smoke, and so the list that he is referring to must be a list of the 4,000 that have been measured in mainstream smoke, and I beg to differ.

The science shows that mainstream smoke and ETS are not the same. They don't have the same constituents, and so --

THE COURT: I thought mainstream smoke and sidestream smoke both made up environmental tobacco smoke.

MR. ENGRAM: When you draw through a filter into a filter, into a scientific filter used to measure, that's the constituents that

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

they have measured for tobacco smoke.

The levels are either metabolized in the body when they are exhaled or dissipated at such level that they can't be measured in the environment, but the dilution and the absorption in the body renders constituents not present in ETS, and the difference is that it is well less than half of the constituents in mainstream.

He is saying they want to put in this list of 4,000 constituents, and I know that he is talking by saying that that he is talking about mainstream smoke measurements, not ETS.

THE COURT: Well, even if it was related to ETS, how is it related to chronic sinusitis?

MR. WEINSTEIN: I know you listened to Dr. Persky. Dr. Persky said that the contaminants and irritants in mainstream -- I am tripping over my words because I am very upset, Judge. That environmental tobacco smoke is substantially the same in terms of the irritants, and he moves on.

Judge, the Surgeon General's -- excuse me, Dr. Burns testified that mainstream and

ETS is substantially the same.

THE COURT: That is not what I am asking.

MR. WEINSTEIN: And the Surgeon General's Report --

THE COURT: I am asking, is there any testimony in our case that any of these thousands of constituents have any bearing on chronic sinusitis?

MR. WEINSTEIN: It is environmental smoke. We have had testimony about it.

MS. WEINSTEIN: Those are the chemicals in smoke.

MR. WEINSTEIN: Those are the chemicals in smoke. You don't have to make a giant leap for that, Judge. It is common sense. We are talking about tobacco smoke.

We have testimony that it is substantially the same environmental smoke and mainstream smoke.

We have Dr. Burns' testimony that says that is why they investigated it, because the prior research has shown that cancer was caused by mainstream smoke. They realized people were getting sick. 3,000 people die every year from mainstream smoke.

THE COURT: Well, you know, I guess some of these constituents are things that cause cancer.

MR. WEINSTEIN: Some are irritants and some are carcinogens. When you say a carcinogen, there are irritants that cause cancer, and there are irritants that don't cause cancer.

Now --

MR. REILLY: Your Honor, what Mr. --

MR. WEINSTEIN: If smoking --

MR. TROP: Judge, direct smoke causes sinusitis. There is going -- I think that is going to be pretty much agreed, and the same --

MR. REILLY: It isn't going to be.

MR. TROP: Well, I think it is. You know, their Dr. Feinstein, who they talk about, even he says there is a direct link of the sinuses, and they are the same compounds in sidestream smoke that are in direct smoke, and Dr. Torres will admit it. He said it six or seven times, so how can they say that sidestream smoke doesn't cause sinusitis when the same thing they get through the cigarette

does?

THE COURT: I agree. There certainly is evidence about that. I am just talking about the various constituents.

Let's go back to the original problem here. These are interrogatories that were objected to. Let me see if there is any way I can rule on the objections on this.

MS. WEINSTEIN: Only on one objection, the question that asks where R.J. Reynolds objects and say we will answer it anyway, and they waived it by answering it.

THE COURT: No.

MR. WEINSTEIN: At least call out their objections. It is your obligation to bring it up.

THE COURT: Could you just give me a minute, please.

MR. WEINSTEIN: It is like filing a motion and not calling it up for a hearing.

MR. REILLY: Judge --

THE COURT: Wait.

MR. REILLY: Judge, I don't have those --

THE COURT: One of your objections is a privilege objection. That one I think you do

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

waive by producing the documents.
There are several questions in the interrogatories, and there is one that is more closely related to this case the way I see it, and that is number 3 which says please identify the specific constituents which Defendants admit are present in environmental tobacco smoke. Some of the other questions are mainstream smoke and sidestream smoke which are carcinogens and which are irritants and which are reproductive problems and reproductive toxicants, but the one that says identify the constituents in ETS I think is certainly arguably related to this case, but I don't know what the answer is aside from the objection.
I mean, I can't tell exactly what the answer is.
MR. REILLY: Your Honor, you have me at a disadvantage.
THE COURT: Let me give it to you. It is the one I marked with a star.
MR. WEINSTEIN: Judge --
THE COURT: Wait, please.
MR. REILLY: Well --

MR. ENGRAM: Your Honor, this response refers the Plaintiffs to a list of ETS constituents published in a book authored by Jenkins. That book is not in evidence and is not an exhibit in the case. There is no --
THE COURT: There is nothing attached that lists them.
MR. ENGRAM: Right. That book is entitled for the record, your Honor, Jenkins and Tompkins, "The Chemistry of ETS, Composition and Measurement." It is a 2000 publication, and I don't have it with me.
MR. REILLY: Your Honor, having looked at the interrogatories and responses to them over objection, what counsel represented to your Honor was going to be included in here isn't in here, which is a listing of the constituents of environmental tobacco smoke.
THE COURT: Well, I don't know what the -- not in that part. The next -- yeah, the next one, what is that?
MR. ENGRAM: That is a listing of tobacco and smoke constituents. That's the 4,000 chemical list of mainstream tobacco.
MS. WEINSTEIN: Does it say it is

mainstream tobacco on there?
MR. REILLY: I think you have to go back to the interrogatory answers and see which one references the appendix.
In response to interrogatory No. 1, please identify the specific constituents which Defendants admit are present in mainstream smoke. And their response, Reynolds' attached Appendix A, which is a list of constituents reported to be present in tobacco and/or tobacco smoke, many of which were first identified by Reynolds' scientists, so this is clearly a list of mainstream smoke constituents, and they've given a different response as to the question of constituents in environmental tobacco smoke. That is the response that was given to interrogatory No. 3 which Plaintiff's counsel don't have here apparently, so for all of the other reasons, we would also object that they are trying to put into evidence irrelevant material, because whatever is in mainstream smoke is not an issue in this case.
THE COURT: Is there any -- I guess all of the witnesses for the Plaintiff have

testified or we know what their testimony will be, because Dr. Richmond is here, but has anyone talked about any of the individual constituents as being related to sinusitis?
MS. WEINSTEIN: Dr. Torres will talk about it.
MR. ENGRAM: He is asked to comment on, you know, is this something that is in mainstream smoke. That's the way his deposition proceeded.
THE COURT: But --
MS. WEINSTEIN: He agreed that the constituents are basically the same.
THE COURT: That is not my question. Is there anybody who says -- I don't think so because I've heard the testimony. There is no one who says constituent X, constituent Y, all of these chemicals, they have an effect on chronic sinusitis.
MS. WEINSTEIN: That is coming.
THE COURT: It is coming.
MS. WEINSTEIN: Dr. Torres.
MR. REILLY: All they have to do, your Honor, is ask the witness, because to be quite honest with you, Dr. Torres did not maintain

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

he had any expertise and he will not maintain he has any expertise in the constituents of cigarette smoke, ETS, in a question, but if they want to ask him whether or not a particular chemical is, one, in environmental tobacco smoke or secondhand smoke, and, number two, whether or not he thinks that it would be somehow connected with causing chronic sinusitis, they are free to do that, but that is not what they are attempting to do with this exhibit.

THE COURT: Well, will the Defendants stipulate there are -- I don't know how many -- 4,000 plus different chemicals in tobacco smoke?

MR. ENGRAM: No, because that is irrelevant to the issue in this case, one, the constituents found in environmental tobacco smoke, not what are the constituents found in mainstream smoke.

THE COURT: I guess there is some list of what is contained in ETS.

MR. ENGRAM: That is in the Jenkins book that we don't have.

MR. WEINSTEIN: Judge, I don't remember

if you cut it out or not because there was a lot cut out, but I believe Dr. Burns testified about the irritants and constituents in tobacco smoke.

THE COURT: We have the testimony, and if you can point to it.

MR. WEINSTEIN: Moreover, Judge, the Surgeon General's Report from 1986 discusses the deposition of particles inhaled, carbon monoxide, and it talks about the constituents of smoke tobacco.

Also in the testimony before the court in Fontana, opposing counsel, Mr. Gariety, and you've seen him in here, he said to the court -- there was another document, and the judge said who is going to substantiate that document? And he said this is a learned treatise. It is a government record, just like the Surgeon General's Report which was already in evidence in that case, and that's -- of course, this has to be -- I maintained all along it is more than a learned treatise. It is a government report that has to be judicially noticed, and it was in the case downstairs, and in every case.

THE COURT: What does it say?

MR. WEINSTEIN: Well, it says deposition and absorption of tobacco smoke constituents, and it lists markers of absorption; carbon monoxide, thiocyanate, nicotine, and varies -- I am sure throughout here, Judge, they list a lot of the constituents in secondhand smoke, and it even discusses they are irritants to the respiratory system.

This is only a report that is required by the government to the President of the United States and to Congress and is part of the Congressional Record, the data reviewed in 17 previous reports, etc., the forward and the preface, and that is why in here they talk about how the constituents in mainstream --

THE COURT: Okay.

MR. WEINSTEIN: Respiratory diseases, irritation, the most common effect of tobacco smokers -- of tobacco smoke exposure is tissue irritation, and the eyes appear to be sensitive to irritation, the nose, throat, airways, and they may also be observed --

MR. REILLY: I object to Mr. Weinstein going on and on. The issue is whether or not

this exhibit comes into evidence, and we object to this exhibit coming into evidence as it is completely irrelevant, and the only portion of it that could have been relevant they didn't bring with them, and that is what are the constituents in environmental tobacco smoke.

THE COURT: Can you get that?

MR. REILLY: Can they get it?

THE COURT: Can you produce it? Did you ever ask them to produce the thing referenced as being a list of constituents in ETS?

MR. REILLY: No, they did not.

MR. WEINSTEIN: I can't hear the question. Did I ever what?

MR. REILLY: Did you ever ask us to produce the Jenkins book, and the answer is, no, he doesn't even know what it is.

MR. ENGRAM: Your Honor, I didn't bring the Leon case with me, so that is why I don't have that information.

MR. WEINSTEIN: Judge --

THE COURT: I am not asking for anything further right now on this.

I am not going to allow you to offer it

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

into evidence, but you certainly can ask witnesses about the constituents in environmental tobacco smoke as it has a bearing on chronic sinusitis.

MR. WEINSTEIN: At this time, Judge, again, we move into evidence the Attorney General's -- the report of the Surgeon General of 1986 which lists many of the constituents of environmental tobacco smoke.

The report is solely on involuntary smoking, tobacco smoke, and its toxicity.

THE COURT: I am considering allowing it in. I have to still think about it. I don't think you need my decision right now. I know you will need it for closing argument.

Will you need it for cross-examining Torres?

MR. WEINSTEIN: Are you using this for cross-examination?

MR. TROP: No.

MR. WEINSTEIN: I would ask the court to go through it.

THE COURT: May I see it again?

MR. REILLY: Judge, you previously ruled.

THE COURT: I don't think I ruled on it.

MR. WEINSTEIN: You said parts.

MR. REILLY: You already allowed them to deal with the parts that relate to this issue. You've allowed the Surgeon General and allowed Dr. Burns to talk about those portions of this report that are pertinent to this litigation, and you ruled that we are able to display to the jury that portion that relates specifically to the issue of our case, which is chronic sinusitis.

THE COURT: There might be other parts in here that are relevant, and I don't think -- I don't think I've determined all of the portions that are relevant.

MR. WEINSTEIN: That is the point. If it goes in, there are a lot of times that reports go in, just like medical records, that aren't --

THE COURT: No. If there are parts that are not relevant, it doesn't go in. If there are parts that go in that are relevant, I will allow you to put them in.

MR. REILLY: Well, we object, your Honor.

MR. WEINSTEIN: In every case, how do we know ahead of time that Your Honor is the only

judge that would rule only parts are in when before the entire report has gone in?

THE COURT: It doesn't matter whether you knew I would rule a certain way or any judge would rule a certain way.

If there are certain parts you are claiming is relevant, I will let you put those in, so you will have to indicate it.

MR. WEINSTEIN: Judge, if I offer in the report and they say that something is irrelevant, it is their burden just as if when they make an objection, they must call up the objection. It is not our responsibility to call up an objection for a hearing. They produce the information with an objection, and then we offer it here at trial, and they say, well, they didn't call up our objections for a hearing.

It is like filing a motion and never calling it up for a hearing. You are supposed to do it.

THE COURT: Well, I would like for you to indicate which parts you think are relevant to the question that this jury has to decide, and, in the meantime, let me write out what I

will tell the jury about the newspaper article.

I will tell them this: You may have seen a newspaper article or heard reports of a decision in another case in Miami against some of the same Defendants that are involved in this trial.

Please understand that that case is an entirely separate case unrelated to this one and should not affect your decision in this case in any way.

Is there any objection?

MR. WEINSTEIN: Yes.

THE COURT: Okay. Other than Mr. Weinstein who objects to any instruction because he thinks that case is related to this case and should affect their decision in this case, is there any other?

MR. WEINSTEIN: No, I don't think it should affect them, but you are mischaracterizing what I said. Obviously, they should be guided by the evidence in the case, but --

THE COURT: Well, I can add something like that.

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

MR. WEINSTEIN: You shouldn't say it is unrelated because it is the same Defendants and it is their product. It absolutely is related. You can say that the evidence that -- they should be bound by the evidence in the case and not by the result reached in that case.

THE COURT: Well, I will add that if you like. Let me see.

MR. WEINSTEIN: I strongly object to saying it is unrelated because I think that is unfair. It is an unfair comment.

THE COURT: You think it is related?

MR. WEINSTEIN: Because I think both cases deal with the affects of tobacco smoke whether it be environmental, which they like to characterize as totally different when it isn't, because all of the experts say it is substantially the same.

MR. ENGRAM: Your Honor, if the court read the article, you also know that that case involved bladder cancer and tongue cancer, not chronic sinusitis.

MR. WEINSTEIN: I know the jury is not smart enough to know that case, if they read

it, involved tongue cancer and bladder cancer.

I assume they know it is a different case, but it still involves tobacco smoke. I think I should state for the record that it seems to me that my opponents just simply believe that this jury has no common sense, and they argue it to the court.

THE COURT: I've added to what I said earlier this case must be decided based only on the evidence in this trial.

MR. WEINSTEIN: And, your Honor, could they add and your own experience and common sense?

THE COURT: No.

MR. WEINSTEIN: They are supposed to disregard that, I guess.

THE COURT: They will be instructed about how that is to come into play in the standard instructions. That is included. Okay. Let's see.

MS. WEINSTEIN: Excuse me, Judge. There is one more item we want to put into evidence, and that is Plaintiff's 1-G for identification, and these are filed in the case of Marissa Mitchell versus Philip Morris.

I understand it is a different case.

These are responses to Plaintiff's interrogatories to each of the Defendants concerning market share of each Defendant. We did not originally intend to put these in. We did list them on our exhibit list. We put them on the later end of the discovery period, but we put them in anticipating the possibility that we might be required to prove it.

The fact that it was in the Mitchell case is irrelevant. It would be the same answers in every case. It just lists specifics which brands for what Defendant and what years they began manufacturing a brand and what year they discontinued it and what the market share was.

MR. REILLY: Judge, we will object to this; however, since I think this is not going to come in at this moment, I mean, it is not going to be presented to the jury at this moment, I think we ought to be able -- since we have just been given this, if you would give us a little time.

THE COURT: I am inclined to allow this in, and if there is some cover page from

another trial, we can take it out of it, but the substance of it.

MS. WEINSTEIN: For the record, we didn't produce it just today. This was produced and made available for copy and inspection years ago.

THE COURT: I mean, I don't -- I'll give you some moments to consider it, but I think it should be admitted.

MR. REILLY: Part of what I object to is this includes all of the objections we make. There is no ruled on objections. There is no reason for the jury to see objections.

THE COURT: I agree.

MR. REILLY: There is no reason for the jury to see the style of the case.

THE COURT: I agree. The only thing put in there is the substance of it. You can -- you don't even have to explain it. You can just say that it is stipulated to or it has been produced by the Defendants.

MR. REILLY: Now that I look at these, I have far more objections. The representation by counsel as to what is contained in here is completely inaccurate or virtually completely

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

inaccurate.
This asks for who is your insurance carrier? Do you have insurance? This includes --
THE COURT: Okay. Well, that is different from market share.
MR. REILLY: This is --
MS. WEINSTEIN: We want to put in the market share.
THE COURT: Why don't you take out the part or segregate it so it won't have the cover sheet or anything about insurance and it will just have the market share part? I don't see any problem with it.
MS. WEINSTEIN: We will need some time to do the appropriate adjustments.
MR. REILLY: Market share information is -- for the record, you have one of these for each manufacturer, is that correct?
The market share for Lorillard is contained in response to interrogatory No. 6. The market share information for R.J. Reynolds is contained in -- this asks for --
THE COURT: Ms. Weinstein said she will go through it and segregate out the part that

talks about market share and resubmit it.
MR. REILLY: Market share information for Reynolds is in response to interrogatory No. 5 -- I am sorry, 6.
MR. ENGRAM: Your Honor, it also goes back to years when the Plaintiff was not flying. I think that it should be restricted to the period of time when she flew and smoking was permitted on the airline, so --
THE COURT: I think that is probable right.
MS. WEINSTEIN: We don't think we have to prove it. I am not sure why we are doing this. Maybe your Honor can rule. I don't know when you intend on ruling or whether we need to bother with it.
THE COURT: If you are offering it, I am allowing it into evidence. If it is there, it is there. You have other evidence about the brands that were being smoked.
I suggest that maybe if the Plaintiffs get a verdict in the case that -- it seems like the issue about which Defendants are going to pay, that is really between the Defendants. I mean, I don't think the

Plaintiff cares who pays them.
MR. REILLY: I don't think that is the law, your Honor, but interrogatory No. 6 --
MS. WEINSTEIN: Correct.
MR. REILLY: -- appears to be the only interrogatory that pertains to the subject that counsel is addressing, and that is to the set of interrogatories, not -- this is why this is so --
THE COURT: I am saying that what can come in is the market share information, and it will be the time period we are talking about,'86 to'90, I guess, or there were some international flights after that.
MS. WEINSTEIN: Well, the lists are going to be really chopped up because, for example, Philip Morris I believe has many, many, many brands, and some start -- the list is single spaced, and some start in '56 and go probably through to date, and right underneath that, you want us to --
MR. REILLY: That is not how the market share information is presented. The market share information is presented in response to

No. 6 year by year, percentage of market share, period, end of story.
THE COURT: Well --
MS. WEINSTEIN: We need to put in the brands as well. I thought we would put the brands in.
MR. REILLY: You didn't say that.
THE COURT: The brands and the market share, so you could put -- I don't know what it looks like. You could highlight the particular time periods we are talking about.
MS. WEINSTEIN: It is an alphabetical list of brands; am I right?
MR. McCUE: The answer is chronological.
THE COURT: Let's not spend a lot of time on this.
MR. REILLY: The brand information isn't here for Reynolds.
MS. WEINSTEIN: If you let us put it in, although not now, but if we have permission to do it in our case in chief later this afternoon, we will.
THE COURT: You can, the brand information and the market share.
MR. ENGRAM: It is not in the response.

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Source: http://www.industrydocuments.ucsf.edu/docs/knjl0001

THE COURT: It isn't there?
MS. WEINSTEIN: It is in some of them. We care more about the market share than the brands. We will put in whatever we have that is either market share or brands.
THE COURT: You will separate it out and show it to them and we will go over it again.
MS. WEINSTEIN: Let me have this.
MR. ENGRAM: It won't have Anita Leon or the style of another case on it, will it?
MS. WEINSTEIN: No, that is what we said.
THE COURT: So we will start with Dr. Torres.
(Jury present)
THE COURT: Good morning. Have a seat, please.
You know, this jury has been so excellent in being prompt, and I am so sorry we make you wait a lot of the times. You are really so good coming on time, and we appreciate it.
I just want to give you one little instruction before we continue, and I will explain what we will do.
You may have seen a newspaper article this morning or heard reports of a decision in

another case that was tried here in Miami against some of the same Defendants that are involved in this case.
Please understand that that case, the other case, is an entirely separate case unrelated to this one and should not affect your decision in this case in any way.
This case must be decided based only on the evidence in this trial and on the law that I will instruct you on at the close of the evidence.
Now, the Plaintiff has not yet rested, but to accommodate the witnesses in getting this videotape prepared, and so on, the parties have agreed that the Defendant will begin its case by calling its first witness before the Plaintiff has rested.
The Plaintiff is still going to be offering the testimony of one more witness through a videotape, and we will do that this afternoon, I believe. So that we can keep the trial moving along, the Defendants will be calling their first witness at this time.
MS. TEDDER: The defense calls Dr. Torres to the stand.

THE COURT: Come right around here, please.
JULIO TORRES, M.D.,
was called as a witness on behalf of the Defendants, and after being first duly sworn on his oath, testified as follows:
DIRECT EXAMINATION
BY MS. TEDDER:
Q. Good morning, Dr. Torres.
A. Good morning.
Q. Dr. Torres, would you please introduce yourself to the ladies and gentlemen of the jury.
A. Yes. My name is Dr. Julio Torres.
Q. And, Dr. Torres, you are an M.D., a medical doctor, correct?
A. Yes, I am.
Q. And I have asked you to come in here today and to share with this jury your opinions regarding sinusitis and whether or not Mrs. French's exposure to environmental tobacco smoke caused her chronic sinusitis?
A. Yes.
Q. Okay. And all of the opinions that you give today will be those that you hold to a reasonable degree of medical probability?

A. Yes.
Q. Let's talk a little bit, Dr. Torres, about your background.
Can you tell us where did you attend medical school?
A. I went to the University of Puerto Rico, School of Medicine.
Q. And what year did you graduate?
A. 1978.
Q. Did you do an internship after medical school?
A. Yes, I did.
Q. And where did you do your internship?
A. At Jackson Memorial Hospital, University of Miami, School of Medicine.
Q. What period of time did that internship encompass?
A. It was from 1978 to 1979.
Q. Okay. Did you do a residency after you completed?
A. Yes, I did.
Q. And what is a medical residency? Can you explain it?
A. That is additional education that you acquire to become a specialist.

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

Q. Okay. And can you tell us what did you focus on in your residency?
A. Well, after my internship, I did another year of general surgery. And then from 1980 to '83, I became a resident in the department of otolaryngology, head and neck surgery, the department of ear, nose and throat surgery, University of Miami, Jackson Memorial Hospital, and in 1983, I became chief resident and graduated.
Q. All right. So your first year of residency was a residency in general surgery and you spent three years in otolaryngology?
A. I did two years of general surgery and three years of otolaryngology.
Q. Okay. Now, can you tell the jury about your training in otolaryngology during your residency.
A. Yes. It was a very intensive program where we were trained to diagnose and treat medically and surgically conditions or diseases of the ear, nose and throat, such as sinusitis, nasal obstruction, cancer of the head and neck, chronic ear infections, problems with allergies, and also problems with vestibular disorders of the ear.
Q. In otolaryngology, I think you also told

us that an otolaryngologist is referred to as an ENT, correct?
A. Yes.
Q. Ear, nose and throat doctor?
A. Yes.
Q. And during your residency, you did have training in diagnosing and treating chronic sinusitis?
A. Yes, I did.
Q. And I think you also said you had training -- well, did you have training in diagnosing and treating things like allergic rhinitis?
A. Yes, I did.
Q. And can you tell us what is allergic rhinitis?
A. Allergic rhinitis basically means an inflammation of the lining of the nose. It is what is also commonly known as hay fever and is characterized by a runny nose, a stuffy nose, sneezing.
Q. Did you also have training in diagnosing and treating allergies?
A. Yes, I did.
Q. Are you board certified in any particular

specialty?
A. I am board certified by the American Academy of Otolaryngology.
Q. And can you tell us how you become board certified as a physician?
A. Well, after you spend four years of premed, four years of medical school, and then five years of residency training, that is 13 years of studies, you sit to take a written test and then an oral test which is given by the American Board of Otolaryngology. They are usually a professor from the departments of otolaryngology from different universities, and once you pass the test, you are board certified.
Q. Do you have any professional certifications?
A. Yes.
Q. Can you tell us what those are?
A. Well, I am a Fellow of the American College of Surgeons, which is the most prestigious college of surgeons in the United States.
I am also a fellow of the American Board of Otolaryngology, Head and Neck Surgery.
I am a Fellow of the American Academy of Facial and Reconstructive Plastic Surgery, and I'm

a member of the Dade County Medical Association and the Greater Miami ENT Society, and I'm also a member of the Florida Society of Otolaryngology.
Q. And I notice that you listed for us right there the American Academy of Facial and -- Facial and Reconstructive Plastic Surgery; is that correct?
A. Yes.
Q. And do you do cosmetic surgery?
A. Only when it is in regards to reconstruction of the effects of the nose.
Q. So only when it is medically necessary?
A. Correct.
Q. Do you do, for example, face-lifts?
A. No.
Q. Are you familiar with collagen injections?
A. Yes, I am.
Q. Can you tell the jury what those are?
A. Well, that is a procedure that is done to try to eliminate wrinkles on the face, and it is usually done just for cosmetic purposes.
Q. Is that something you do in your practice?
A. No, I don't.

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

Q. Okay. You are licensed to practice medicine, Dr. Torres?
A. Yes, I am.
Q. And can you tell us where you are licensed to practice?
A. In the State of Florida.
Q. Thank you.
Let's talk a little bit about your work history.
After you completed your internship and your residency, where did you go to work?
A. I worked for two years with two prominent otolaryngologists in the community, Dr. Ruth (phonetic) and Dr. Robert Simons. They were located in North Miami Beach.
And after two years, I opened my solo practice at Palmetto General Hospital in Hialeah, and since then I have been working solo, and for the last -- well, since 1985, and recently we created a group called South Florida ENT Associates, and I am a group member in there practicing ear, nose and throat surgery.
Q. You have been in private practice a total of how many years?
A. 19 years.

Q. And are you affiliated with any hospitals?
A. Yes, I am.
Q. And can you tell us what those are?
A. Palmetto General Hospital, Miami Childrens Hospital, and Doctors Hospital.
Q. And have you held any positions at any of those three hospitals that you've talked about?
A. I've held positions in Palmetto General Hospital.
Q. And can you tell us what those are?
A. Yes. I have been chief of the ENT division twice, most recent one in 1997. I have been a member of the Executive Committee at the Palmetto General Hospital, and I am a member of the Otolaryngology Committee for many years as well.
Q. You mentioned that you have been a couple of times chief of the division of otolaryngology?
A. Yes, I have.
Q. At Palmetto?
A. Yes.
Q. And can you describe to us just generally what that position would have involved.
A. Well, we have approximately 15 or 16 otolaryngologists at Palmetto, and we are involved

with the daily supervision and activities of the department, the needs of the emergency room, the needs of equipment in the operating room, and if there are any clerical or medical problems that relate to the specialty, then you are to organize and solve them.
Q. Would it be fair to say that when you are chief of a division, you really are responsible for running that division for that department?
A. Yes.
Q. Do you have any teaching appointments, Dr. Torres?
A. Yes, I do.
Q. And can you tell us briefly what those are?
A. Well, from 1983 to 1997, I was a clinical instructor at the University of Miami, School of Medicine, department of otolaryngology, and from 1997 until the present, I am on a voluntary faculty teaching residents and students. They rotate through my office, and I teach them all of the different aspects of my specialty.
Q. And in addition to your hospital affiliations and the teaching appointments that you talked about, do you actually see patients, have a

patient care practice?
A. Yes, I have my own private practice.
Q. And can you tell us approximately how many patients you would see in a week?
A. An average of around 175 patients a week.
Q. And all of those patients come to you for problems related to the ear, nose and throat; is that correct?
A. Correct.
Q. And can you just tell us briefly during your 19 years of practice what types of ear, nose and throat disorders have you treated?
A. Well, I have a special interest in problems of sinusitis and nasal conditions, such as nasal obstruction, chronic and acute sinusitis.
I also treat patients with problems, such as oral cavity cancer, laryngeal cancer, and I also treat patients with chronic ear infections and head and neck tumors and cancer.
Q. And can you tell us approximately what percentage of the patients you treat suffer from chronic sinusitis?
A. I get referrals for that kind of -- probably about 50 percent of my patients come with problems related to the sinus.

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support for www.industrydocuments.ucsf.edu/docs/knjl0001

Q. Have you treated flight attendants in the past, Dr. Torres?
A. Yes, I have.
Q. Are you familiar with the term functional endoscopic sinus surgery?
A. Yes, I am.
Q. Can you tell us what that is?
A. Well, that is a relatively newer kind of surgery that is performed in the sinuses. It is a technique that was imported from Europe, Austria and Germany, in the 1980s.

Basically the scientists there did a lot of research and they came up with this technique where we use the instruments called endoscopes that allow us to look all the way into the nose and do a very good operation which is a lot less painful and with a lot better results than the kind of operation that we used to do before.
Q. And what is the purpose of functional endoscopic sinus surgery?
A. The purpose is to alleviate the areas of obstructions inside of the sinuses and eradicate infection by doing that.
Q. If I understand what you said correctly, one of the major purposes is to remove whatever

blockage there may be in the sinus; is that correct?
A. Correct.
Q. And so if there has been testimony in the case that the primary purpose of functional endoscopic sinus surgery is to establish ventilation, would that be correct, in your opinion?
A. Yes.
Q. Okay. Is it fair to say that a substantial portion of your medical career is devoted to the treatment of sinus disease?
A. Yes.
Q. And have you diagnosed and treated patients like Mrs. French who have complained of suffering from ear, nose and throat disorders?
A. Yes.
Q. Okay. Have you published any peer-reviewed articles?
A. Yes.
Q. Okay. And, first, can you tell us what the term "peer review" means?
A. It means that you have completed your research and you've prepared a document and it is reviewed by prominent physicians, in our case

otolaryngologists, who are usually chiefs of the hospitals of a particular department, and they approve the methodology you use and that the results are accurate and they can be shared with the rest of the medical population.
Q. And can you tell us what you've published?
A. Yes. I published an article in the journal called Head and Neck Surgery which was called Prognostic Institutional Evaluation on Patients with Adenocarcinoma of the Head and Neck.
Q. When was that article published?
A. In 1983.
Q. And the Journal of Head and Neck Surgery, is that a peer-reviewed publication?
A. Yes, it is.
Q. Okay. All right. Over the course of your career, Doctor, have you received some awards that we haven't talked about yet?
A. Yes, I have.
Q. Can you tell the jury briefly what those awards are?
A. Well, since 1996 through 2002, I have received the Nova Southeastern College of Medicine Award for outstanding teaching within my specialty.

That is from 1996 to 2000.

I also received from Palmetto Hospital an award for outstanding leadership in the division of otolaryngology in the year of 1996 and 1997, and I also received an American Academy -- correction, American Medical Association Outstanding Award for continuing medical education.
Q. Doctor, we've talked a little bit about your practice, your teaching and your hospital affiliations.

Is there anything else that you are involved in from a medical perspective?
A. Yes, I am.
Q. And what is that?
A. Well, I've also performed medical missionary work in Central America since 1999. I organized groups of doctors and volunteers, and we go to Guatemala and take medications, and we spent a week there treating the poor people in the country for free. We have been doing that now twice a year, and we also are organizing a similar activity here in Miami through the Bascom Palmer clinic where we expect to be able to provide free medical care to the poor immigrants that cannot afford that kind of healthcare here in Miami.

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Document from www.industrydocuments.ucsf.edu/docs/knjl0001

Q. Dr. Torres, were you hired by the Defendants in this case to review the medical records of Mrs. French and to give us your opinions?
A. Yes, I was.
Q. And before being retained by the Defendants in this case, had you ever dealt with any of the tobacco companies?
A. No.
Q. And prior to testifying here today, have you ever testified in a case involving a tobacco company?
A. No.
Q. And before you testified today, have you testified in any context?
A. No.
Q. Okay. Can you tell the jury a little bit about how it is you came to be involved in the case?
A. I got a phone call from an attorney, Lorraine O'Neal, at Shook, Hardy & Bacon. She heard from my daughter who was at that time a college student and was doing a clerkship, and she asked to interview me.
Q. Okay. And you ultimately talked to Ms.

O'Neal, correct?
A. Yes.
Q. And became involved in the case?
A. Yes, I did.
Q. And does your daughter work for Shook, Hardy & Bacon?
A. No, she doesn't.
Q. Okay. Before you began to work with the Defendants, did you take certain steps to satisfy yourself whether or not secondhand smoke causes chronic sinusitis?
A. Yes, I did.
Q. And can you tell the jury what you did?
A. Well, I reviewed literature on my own from my books and journals, and I reviewed literature provided by the Shook, Hardy & Bacon attorneys.
Q. And when you say you reviewed literature, what was the purpose of your literature review?
A. I wanted to learn everything that had been written about the possibility that ETS or secondary smoke could be related to chronic sinusitis in any way, shape or form.
Q. And, in addition, do you rely on your own experience in private practice?

A. Correct.
Q. And did you reach some conclusions about whether or not ETS caused chronic sinusitis?
A. Yes, I did.
Q. And what was the conclusion you reached?
A. That ETS doesn't cause chronic sinusitis.
Q. Dr. Torres, how many cases were you asked to look at by the Defendants?
A. Two.
Q. And have you been paid for your work in the case?
A. Yes.
Q. Can you tell the jury what is your fee for giving trial testimony like we're doing here today?
A. The average fee is about $500 an hour.
Q. Okay. Is that the same fee you would charge for reviewing records, for example?
A. No.
Q. What is the fee for reviewing records?
A. $350 an hour.
Q. Okay. And have you done work like this before?
A. No, I haven't.
Q. Okay. Well, knowing that you haven't

really done this kind of work before, but the charges which you've just talked to us about, are those the normal kinds of rates that you would charge anyone for a similar kind of medical record review --
A. Yes.
Q. -- or testimony?
A. Yes.
Q. And can you tell us how much you have charged for your work in this case?
A. For Mrs. French's case?
Q. Yes.
A. Around $20,000.
Q. Okay. I would like to turn, Doctor, and talk for just a little bit about the sinuses, what they are, and how they work.
And to do that, do you have a diagram of the sinuses which would assist you in explaining your testimony to the jury?
A. Yes, I think we have the diagram right there.
Q. Okay. Let me pull out this diagram. Let me move this a little bit. All right.
Dr. Torres, as we explain this to the jury, would it help you a little bit to come down

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

from the stand? Is that all right?
THE COURT: Okay.
BY MS. TEDDER:
Q. Can everyone on the jury see this? Okay.
Dr. Torres, first, can you tell us what is the sinus system?
A. The sinus system are cavities that are located on the forehead right here and between the eyes. They are called the frontal sinuses and --
THE COURT: Just a minute. I am sorry. I don't know if there is a way to use this microphone, or if you could speak more slowly. I don't know how far it reaches.
BY MS. TEDDER:
Q. Okay. Maybe we can start again and you can explain the sinus system.
A. The sinuses are cavities located on the forehead right here.
Q. Two?
A. The frontal sinuses, yes, and then you have the ethmoid sinuses which are located right here. They are between the eyes right here.
A lot of times people with sinus headaches say my nose hurts right here.
Then you have the bigger ones which are

called the maxillary sinuses which are actually located below the eye.
Q. And you are pointing to the cheekbone area?
A. Yes, the cheekbone, and then you have the splenoid sinus in the front of the head, and you don't see it here on this particular view.
Q. Okay. What are the purpose of the sinuses?
A. Well, the purpose is not very well -- there are some theories that basically they kind of decrease the weight of the facial skull or, otherwise, you would be walking like this (indicating).
They also help in the resonance of the voice. That is why when people have sinusitis they sound like nasal, and they have a little bit of problems in communication of the air that we breathe. It is really more related to the inside of the nose by itself.
Q. Okay. And how many sinuses do we have?
A. A total of eight.
Q. Okay. And are the sinuses connected with the nose or the nasal passageway?
A. Yes, they are.

Q. And can you tell us how they are connected?
A. Well, they are connected through little openings which are called the ostium.
Q. Ostium?
A. Ostium, meaning hole in Latin. Here you see it is a connection there. That is what we call the ostium. All of them have tiny openings in the nose.
Q. Okay. I think we have at drawing over here, and I don't know if this will help you describe the air moving through the nasal passageway any better than this one.
A. Yes.
Q. Okay. We will just move this one. Let's leave this here.
All right. What are we looking at here, Doctor?
A. Well, here we are looking at the inside of the nose. This would be the right side of the nose. You can see this is the outside of the nose, the part that moves, and then this is the opening that we get the air from.
These structures are called the turbinates or also called conchas which are the

structures that help to humidify, filter, the air, remove particles.
And right here, over here, you cannot see them because they are very small, but we have some of the openings of the sinuses.
Q. So when we breathe in air, take a breath of air, what happens to that air?
A. Well, the air will go in through the nose, okay. The vast majority of it will go straight to the back of the throat, the nasal pharynx, and make its way to the trachea and eventually to the lungs.
Q. Okay. And when we breathe in air, does that air go into our sinuses?
A. Well, it doesn't go in -- you know, most of the air will go in through the nose and through the nasal pharynx and through the lungs, but there will be a little bit of diffusion of the air in the sinus.
As you can see, this big structure here is designed to cover the openings of the sinuses, so most of the air will bypass that opening and go straight to the lungs and a little bit will kind of diffuse here.
Q. And if the air went into our sinuses, you

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

talked about -- it would go in through the ostia you talked about?
A. Yes.
Q. And the ostia, there has been some testimony in this case that the ostia might be as small as the head on the end of this pen.
A. Correct.
Q. So that is the tiny openings in the sinus?
A. Yes.
Q. All right. When we breathe in air, what is more important when we breathe air, the function of the nose or the function of the sinus?
A. The function of the nose.
Q. Okay. Are sinuses expandable like our lungs when we breathe?
A. No, the sinuses are kind of rigid. They are solid. They are basically bone, a bony structure.
Q. Okay. All right. Can you tell us how the sinuses work?
A. Well, the sinuses are covered by a lining called mucosa, and that lining produces mucus, and it also has silia, which are finger-like structures that kind of push the mucus and particles from

inside of the sinus up into the nose.
Q. Okay. I want to talk just a little bit about a couple of things you said there.
Mucosa, you said the lining is called mucosa?
A. Yes, it is.
Q. Okay. And basically what is the mucosa?
A. The mucosa is a structure which is like -- well, like on the outside you have the skin, and inside of the sinus, we have this particular different type of lining that covers the inside of the cavity.
Q. So it is just the lining on the inside of the cavity?
A. Just the lining.
Q. And you also talked about something called silia.
A. Yes.
Q. What is the silia?
A. The silia are like finger-like projections, like hairs. They are tiny. You can't see it without a microscope. They are part of that mucosa lining.
Q. The mucosa is covered with the silia; is that correct?

A. Yes.
Q. And what is the purpose -- first of all, the mucosa is not the same thing as mucus, correct?
A. Right. That is the actual secretion when you have a cold, stuffy nose. The mucosa is the lining.
Q. What is the purpose of the mucosa being covered with silia?
A. So that it will sweep out secretions into the ostium that we showed before and eventually into the nose to be eliminated.
Q. And how does it sweep out the secretions that you just talked about?
A. Well, it is a very organized way, okay. The silia will meet and it always meets towards the natural ostium.
Q. The natural ostium?
A. Yes, the little opening we showed before.
Q. I have another chart over here. Would that help?
A. Yes.
Q. Sure. You can take a look at that and that will help you demonstrate how the silia leads to the natural ostium, correct?
A. Yes.

Q. And this is kind of a rough drawing here, Doctor, but can you tell us what would we be looking at here? What is this structure?
A. This is the maxillary sinus which is right here under the eyes.
Q. Okay.
A. The way the silia works -- and this is the basis of the surgery called endoscopic sinus surgery. The scientists found that all of this silia is hairs and will also lead toward this particular spot.
Q. You say this particular spot, and I see two spots on here, Doctor.
If this was a sinus, what would these two spots represent?
A. This most likely represents what we call accessory sinus opening or an accessory ostium, which is like a secondary structure.
Q. So we are looking at your sinus and there are two little holes here?
A. Yes. Some people have two holes, but the significance is that the accessory ostium is not functional. In other words, as you can see here the way God made the sinus, he made all of this area work so that the secretions will go up here,

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

and so there nothing happens.
Q. I want to understand. The red lines demonstrate what, these little red arrows that go to the hole at the top?
A. And that is the natural ostium.
Q. And this is the flow of the mucus?
A. Yeah, the mucus is being pushed there by the cilia.
Q. We have the little silia, the like hair moving, and you said how do they move?
A. Like a wave like, you know, in the football stands where they do the waves, like that (indicating).
Q. And they all move up to the natural ostia?
A. Yes.
Q. And the purpose is to -- what are they taking out?
A. They are in the nose and usually you swallow them or occasionally you blow them.
Q. All right. You talked about the accessory ostium.
Can you point to us again where that is, which one is the accessory and which is the natural?

A. This would be the natural one and this depicts the accessory ostium.
Q. And does everyone have an accessory ostium?
A. Not everybody.
Q. Why do some people have an accessory ostium?
A. Well, it is a developmental phenomenon. Some people have big noses and some people have little noses, and so it is just by chance.
Q. Okay. What effect, if any, does tobacco smoke have on the silia?
A. Well, there have been investigations and research done, and they found that sometimes the silia will be a little faster or a little slower and sometimes they will not be very well at all, but the vast majority is the first ones I mentioned.
Q. Are silia paralyzed by the tobacco smoke?
A. No.
Q. Are there any tests that can be done to determine whether in a particular person the silia is affected?
A. Yes.
Q. Okay.

A. That test was performed by scientists in Germany where they put little carbon particles inside of the sinus, and then they would measure the activity, and it could be shown how the silia would move the carbon particles up into the opening and ostium of the sinus.
Q. I want to talk again for a minute about the accessory ostium.
Can that play a role in the development of chronic sinusitis, the extra little hole that we have down there that none of the silia is moving anything to?
A. Well, that is the only opening that you have in a sinus. It will have chronic sinusitis because it really is a nonfunctional entity.
Q. Which means that if you only have this one, does the silia move everything toward that accessory ostium?
A. No. It has been very well proven in the medical literature that the silia will bypass -- the secretions bypass that area.
Q. They are still looking for the natural ostium?
A. Yes, they are.
Q. Okay. Let's take another look at the

drawing of the sinus and just make sure that we have covered everything.
I will take that one. All right.
I see something on here, Doctor, that we haven't talked about called the middle nasal concha and the interior nasal concha.
Can you tell us what those are?
A. Well, concha and turbinates are kind of more or less the same term. It depends on the translation. But as you can see, the concha, which is this one in the middle, and this one is the interior one is the bony part, that area covered by the mucosa becomes--
Q. Is it better depicted on this one?
A. Yes. The concha becomes the turbinate when it is totally covered by the mucosa and the silia that we described before.
Q. And the concha or the turbinate would be where on the drawing?
A. Right here (indicating).
Q. Okay. All right. And what is their function?
A. The turbinates will filter the air, warm the air, remove particles, so that by the time it gets to our throat and actually to our lungs, it is

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Stanford/Powered by www.industrydocuments.ucsf.edu/docs/knjl0001

warm, and it is not cold, and it has the right humidity.
Q. I want to come back and talk about the turbinates in just a minute, but I want to make sure we have covered everything on the drawing.
I see something on the bottom called nasal septum.
Can you show the jury where it is and tell us what it is?
A. Yes, the nasal septum is right here in the middle. It is this partition that makes or divides the nose into the right and left nasal cavity. It is made of cartilage and bone.
Q. And I see you keep pushing the top of your nose.
Is the septum what we feel if we kind of push on it?
A. Yes, exactly.
Q. All right. But there is something called the middle nasal meatus in the middle of that.
Have I got that correct?
A. Yes.
Q. And what is that?
A. Well, this is this space right here, okay, just below the middle turbinate and the upper

turbinate. The important thing about this area is most of the sinuses drain into that area, so if that area is blocked, then the patient will have problems with sinusitis because the drainage will not be appropriate.
Q. So when you do an exam of someone, is that something you look at?
A. Yes, it is a very important area that we always want to inspect.
Q. Okay. Again, I want to go back and talk about what you were just telling us about a minute ago, the turbinates.
You told us they warm and humidify the air we breathe?
A. Yes.
Q. All right. Are you familiar with the term called concha bullosa?
A. Yes, I am.
Q. And can you tell the jury what does that term mean?
A. Well, one of the anatomical problems that a patient can have that will predispose a patient to sinusitis is -- this is very thin, right, and, well, there are a lot of patients who have a big, big middle turbinate, and it is this big. It will

kind of obstruct all of that area, so that is what we call concha bullosa. Bullosa means it is like a ball instead of being like a concha like this. It is wide and full of air, and a lot of times secretions accumulate in there.
Q. So it is filled with air and it fills up kind of like a balloon?
A. Yes. It is usually filled with air, but the problem is that the fact of the wide structure when it becomes full of fluid and it can eventually become infected.
Q. Can it also press against the nasal wall and block the ostium?
A. Yes, it can. You can see this patient is sort of narrow, see, so this is wider than all of this area, and it is blocked, and the secretions stay here and here, and the patients get an infection and the pus in the nose and the headaches, and so forth. They are typical of sinusitis.
Q. Can you tell us when does a concha bullosa develop in a person?
A. Well, that is a congenital problem; in other words, you are born with the possibility of getting a concha bullosa. And just like I said

before, some people have a big nose and some people have a little nose and some people will have the tendency to -- the time the sinuses develop, which are probably between seven to 12 or 13 years of age, sometimes the turbinate becomes very wide, and that is what we call a concha bullosa.
Q. So you said seven to 13 years of age. Does that mean it would be developed by that point in time if you have that?
A. Yes.
Q. Okay. When do ENT doctors like you learn about what a concha bullosa is and when during a person's lifetime a concha bullosa develops? When do you learn that as a doctor?
A. Well, we start studying the anatomy of the sciences and the head and neck from the first year of medical school. One of the most rigorous rotations that we do is studying the head and neck anatomy.
Now, once you finish your medical training and you go into the specialty of ENT, then we really spend a lot of time studying the facial skull, the sinuses, the structures, so all along medical school, and then eventually during the ear, nose and throat residency program, we will get a

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

lot of exposure studying and understanding what a concha bullosa is.
Q. So if Dr. Persky testified that he did not learn in his medical training about when a concha bullosa develops, would that be inconsistent with your training?
MR. TROP: Objection.
THE COURT: I am sorry. Let me see. I'll sustain the objection. Sustained.
BY MS. TEDDER:
Q. Have we covered everything on that chart, Doctor? I think we've explained all of those terms; would that be correct? Have we explained everything?
A. Yes.
Q. I guess we didn't talk about ethmoid cells. I see that.
A. The ethmoid cells are like the sinuses that are located between the eyes, and we have the anterior ethmoid cells in front and we have the posterior ones which are behind, and they are important because of the research that was done that show us how we can do the surgery better by doing the endoscopic surgery. It was found that sinusitis will start with problems in the anterior

ethmoid cells, so that area usually has to be checked with an endoscope or with x-rays, such as a CAT scan.
Q. Okay. You mentioned an endoscope, and that is something I want to talk about in just a minute.
In fact, is an endoscope something you use to help diagnose a patient?
A. Yes, I do.
Q. And I want to talk about certain diagnostic techniques, and I think you may be able to take the stand again, Doctor.
We will talk about a few of those. We have heard some testimony in this case and several references to the term CT scan.
Are you familiar with that term?
A. Yes, I am.
Q. And can you tell the jury, tell us, what is a CT scan?
A. A CAT scan is a computerized x-ray; in other words, they put together a common x-ray -- I need a little bit of water.
Q. Would you like some water?
A. Yes. They get an x-ray, and it is combined with a computer, and what happens is you

get a very, very, very clear x-ray of what is going -- you can see the sinuses a lot, lot better.
Q. Here you go, Doctor. See if that helps a little bit.
A. Thank you.
Q. Sure. You said it was a computerized x-ray of the sinuses?
A. Yes. A CAT scan is a very -- a very good test. It combines the x-ray with computer image and that allows us to see the inside of the sinuses in a very nice way.
Q. Okay. And when you say it allows you to see the inside of the sinuses in a very nice way, what do you mean?
A. Well, it means that we know we can tell if there is blockage or fluid or infection or polyps.
Q. Okay. Well, what are polyps?
A. Polyps are like little growths that sometimes grow in the nose and predispose patients for sinusitis.
Q. What kind of abnormalities would you look for with a CT scan?
A. First we would want to see if the patient has a concha bullosa which is a very common and a

very easily correctable problem that can predispose the patient to have sinusitis.
We also look to see if there is what we call blockage of the drainage of the sinuses; in other words, if that area called the ostium of the sinuses is open or closed, and we also look to see if there is any deviation of the septum, if there is any fluid accumulation, if all of the sinuses are present or if some of them are absent, so it gives us a lot of very, very key important information that we really need to know before we decide if the patient will get better on antibiotics or if the patient will eventually need an operation to cure the sinusitis.
Q. Dr. Torres, are there different types of sinusitis?
A. Yes, there are.
Q. And I think the jury has heard some testimony in this case as to acute sinusitis, and certainly we've heard the words chronic sinusitis.
Those would be different types of sinusitis?
A. Yes.
Q. We are going to talk about those types in just a minute, but my question would be, with

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Source: http://www.industrydocuments.ucsf.edu/docs/knjl0001

respect to your testimony about a CT scan, can a CT scan help you differentiate the type of sinusitis when you look at it and try to make a diagnosis?

A. Yes, it can.

Q. And how can it do that?

A. Well, if you see a CAT scan and all you see is the air fluid level and the opening and the opening is not compromised and the mucosa doesn't look thickened, it means you are basically dealing with an acute sinusitis. And if you see a lot of inflammation of the mucosa and blockage of the air, that opening to the nose, then basically it means that the patient has a chronic sinusitis, so it is used to help us establish a classification.

Q. We talked about an air fluid level in the sinus.

Is there any way on this drawing that we have here that you can show us what you mean by that?

A. Yes. As you can see, normally the sinuses only have air. If you have air, there is no problem. When there is mucus, accumulated fluid, okay, that means that it's a good medium for the bacteria to start growing, and that is really typical of an acute sinusitis.

Q. Okay. All right. I want to talk about something else you mentioned, and I think you can -- I am sorry for all of the cords on the floor here.

You mentioned something earlier called an endoscope, and I would like for you to take a moment and tell the jury what is an endoscope.

A. An endoscope is a very good piece of our instruments. It is an instrument we use into the nose and up into the sinuses. There are two kinds. We have the flexible which is like made out of rubber with a light inside, and we have the rigid which is metal and has a light on the tip also, and I have two of them here.

Q. All right. I was going to ask you. You brought an example of an endoscope to show to the jury?

A. Yes, I did.

Q. Can we take a look at that? Is that your black medical bag?

A. Yeah.

Q. Wherever it is easiest for you, Doctor. You will have to kind of pick it up and tell us what we are looking at.

A. This is called the flexible endoscope.

See, it is kind of soft. Okay. This we connect -- do we have an outlet?

MR. ENGRAM: Above your head. It is all the way up there.

THE WITNESS: The endoscope is this which allows us to go inside of the nose. See, we can put it in here.

BY MS. TEDDER:

Q. Do you want this one down, Doctor?

A. Yes. We can put it in through the nose, and we can go up here where we want to see, and we can actually go all the way here, and we can go actually all the way into the vocal cords.

Now, it is connected to a light source. It is very bright. Then the light comes through here. When you look through there, you see a lot of stuff that is very hard to see otherwise.

Besides that, we also have a different kind, which is --

Q. Well, first go ahead and tell us about the other kind. I am sorry.

A. This one is called the rigid endoscope, and this is the one we use in order to do surgery, and the reason is that it is rigid, and we can use the other hand to manipulate. So when we do the

surgery, we are putting this instrument here, and we are looking through here or sometimes we hook it to a TV monitor, and then with the other hand, we are able to see exactly where we want to go, which is the basis of endoscopic sinus surgery, because before with sinusitis, we didn't have good visualization.

THE COURT: Good what?

THE WITNESS: Visualization.

BY MS. TEDDER:

Q. I am sorry.

A. That is versus what we used to do before, which was use the head mirror, and then just look through here and use this.

Q. When you say "use this," what are we looking at?

A. A nasal speculum which is what we used before we had this technology.

Q. You used a speculum before you had the endoscopes?

A. Yes, and then we would shine the light here and look through here, but as you can see, it is very hard to see anything when you compare examining it like before versus this. It is a big advance.

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Generated on www.industrydocuments.ucsf.edu/docs/knjl0001

Q. All right. The endoscope helps you and obviously gives you light, correct?
A. Yes.
Q. And then it helps you see better into the nasal -- into the nose and the sinus cavity?
A. Correct.
Q. Okay. And can you conduct an exam, Doctor, an exam on a patient that you think has sinus problems without an endoscope?
A. It would be a very, very poor examination.
Q. Okay.
A. You really have to use endoscopes in order to have an appropriate examination for a patient with sinusitis.
Q. And can you tell us how common is the use of the endoscope that you've brought? I think you can take the stand now. I am sorry, Doctor.
A. It is extremely common. Any otolaryngologist who is familiar with the new techniques in ear, nose and throat and who is performing the surgery, we use it in every patient that has a problem related to the sinuses.
Q. And do you use an endoscope in an examination of your patients with a problem related

to the sinuses?
A. All the time.
Q. And through the use of a speculum alone, the little thing that you showed us, through the use of the speculum, can you reach a conclusion about the sinus?
A. Not a very good one, okay, because all you see is basically, you know, a little bit of the septum and a little bit of the entrance of the nose, but you will not be able to go into the creases, which I just pointed out, unless you do an endoscopic examination with the pieces of equipment.
Q. If I understood what you showed us with the speculum, you open just this area a little bit and you can see whatever you can see with the naked eye?
A. Yes.
Q. And with the endoscope, you are able to go back into the cavity that is represented on this demonstrative exhibit and see back towards the sinus cavities; is that correct?
A. Yes.
Q. You can actually see what is going on with the sinus cavities with the endoscope?

A. Pretty much.
Q. All right. I want to talk a little bit now about sinusitis.
Can you tell the jury what sinusitis is? We heard the term a lot, but what is sinusitis?
A. Well, sinusitis is an inflammation, okay, or an infection of the cavities that are known as the sinuses. They are the bones we described before on the forehead, frontal, between the eyes, the ethmoid, maxillary, and the splenoid.
Q. And how does that infection or the inflammation you are telling us about in the sinus, how does that occur?
A. Well, it is usually started by a viral infection, such as a common cold. You get this virus inside of the nose that causes a swelling and causes edema, and then the secretions become entrapped and the bacteria can come and it starts growing and that becomes an infection which is known as sinusitis.
Q. And that infection creates the blockage that you told us about earlier, which is blocking the little ostia, the hole in our nose where the mucus drains out, correct?
A. Correct.

Q. Are there different types of sinusitis?
A. Yes, there are.
Q. Okay. We talked a little bit earlier about two of those terms that we've heard here. One was acute and one is chronic sinusitis.
Can you define acute sinusitis?
A. Yes. Basically acute sinusitis is an infection of the cavities of the sinuses that usually last -- depending on the classification, the symptoms will last less than 12 weeks, but most people say it usually lasts less than four weeks, but there is complete resolution of the symptoms after treatment with the proper antibiotics.
Q. When you say complete resolution of the symptoms, what do you mean by that?
A. Well, usually the patient with sinusitis will have nasal obstruction, purulent nasal discharge, pressure or sinus headaches, and they will have a postnasal drip, which is like phlegm in the back of the throat, and sometimes they have a cough, so once you treat a patient with the proper antibiotics for the proper length of time, those will disappear completely.
Q. You said with acute sinusitis that is about four weeks, so if you have acute sinusitis,

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

you get the treatment, your symptoms resolve in about 30 days, correct?

A. Yes, about.

Q. And what is chronic sinusitis? How is that defined?

A. Well, chronic sinusitis is an infection in the sinuses that typically doesn't respond to treatment. It will last 12 weeks, and the patient will still have the symptoms, most of the ones that I previously described, plus also when we do a CAT scan, we find that there is thickening of the membranes inside of the sinuses, and usually there is blockage in the area of the ostium we described before.

Q. Okay. And are you familiar with the term subacute sinusitis?

A. Yes. It is a term. You know, we don't use that much in our practice in the sense that we are basically dealing with acute or chronic sinusitis.

Q. The definitions that you've just given us for acute and chronic sinusitis, are those definitions accepted by the American Academy of Otolaryngology?

A. Yes, they are.

Q. And are those definitions that are commonly used by ENTs?

A. Yes, they are.

Q. And those are the definitions you actually use in your practice with patients when you see them when you are trying to determine am I looking at an acute, am I looking at a chronic?

A. Yes, I use them.

Q. Okay. Why do doctors distinguish between acute and chronic sinusitis?

A. Well, it is important because the vast majority of the patients with acute sinusitis will improve with medication, with antibiotics. Usually surgery is not necessary. Whereas, patients with chronic sinusitis, they usually will at some point require a surgical intervention to clear the blockage.

Q. And is the CT scan necessary to diagnose the chronic sinusitis?

A. Yes, it is.

Q. What are the suspected causes of sinusitis?

A. Well, you have different ones. You have the anatomical problems, such as a deviation of the nasal septum, the cartilage. If it is crooked, as

you can see, it is blocking the sinuses, the opening.

You have what we talked about before, which is like the concha bullosa. If you recall, it is like the middle turbinate area is very wide and blocking the area of drainage.

You can have allergies also because, you know, if you have a lot of swelling in your nose, and the nose is stuffy, it is going to be very difficult for the secretions to come out into your nose.

Q. All right. We have a couple of charts here, Doctor.

Would these assist you in talking about the causes of sinusitis?

A. Yes.

Q. The first chart that we have to look at here is called --

THE COURT: Can the Plaintiff see it?

MS. TEDDER: They've seen it.

BY MS. TEDDER:

Q. Predisposing anatomic abnormalities. This chart lists three things; a deviated septum. What is the deviated septum?

A. Well, that is the cartilage that we

described before, and do you have a marker?

Q. Yes, I do. I do have a marker. I have a red one and a black one.

A. The septum -- if you look inside of the nose, which is here, the septum is supposed to be straight. If you have the septum which is crooked like that and is hitting the openings of the sinuses, then the secretions will stay in there. So that is why a deviated septum can predispose the person to sinusitis.

The concha bullosa, if we look at the inside of the nose, which is like a pyramid, and you have the septum here, and you have the interior turbinate here, and all of a sudden you have this structure in there blocking here, you can see this is the sinus here and here, the secretions will not come out.

And then the small ostium, as we discussed before, if you have the sinuses which is suppose to have an ostium like this, if all of a sudden that ostium is tiny, it is going to be more difficult for the secretions to be eliminated, so there is a bigger chance of the secretions staying behind from infection.

Q. And each one of these abnormalities,

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

these are the anatomic things you talked about, things we are born with?
A. Yes.
Q. All right. And we also have on this other chart some other things you mentioned; allergens, for example, as a suspected cause of chronic sinusitis.
Can you just kind of explain this chart to us, Dr. Torres.
A. Yes. A viral infection of the airway of the nose, the most common one is the cold. Every time we get a cold, there is going to be a lot of inflammation in the nose and secretions that can accumulate.
You can have a viral sinusitis just if -- if it is infected with a virus.
Now, a lot of times this will be number one, and then the bacteria will find a very good medium to grow. Where there used to be a viral sinusitis, it grows, and you can see the pus and the yellow stuff. You can blow your nose and see the green or yellow stuff coming out, and that is what we call the bacterial sinusitis.
Q. And I see fungus and dry air listed on here.

A. Right. Fungus, again, is -- a normal growth of the fungus in the sinus that can cause infection. It is important for air to dehumidify and filter, and if we are breathing dry air, that alters the function of the nose and sinuses, and that will also predispose the patient for sinusitis.
Q. And you mentioned allergens.
A. It is a very common problem where if you get the stuff you are exposed to, like pollen or house dust or you are allergic to cats or dogs and you are exposed to this, and so forth, you will get a lot of edema, inflammation, which will allow the bacteria to start growing in the sinuses.
Q. And the last two are immune response and barotrauma.
A. If you have a patient that for whatever reason is immunosuppressed, sometimes the patient has to be on medications called steroids and anti-inflammatories, and if they have problems, the immune response is diminished, and it is easy for bacteria to start growing in the sinuses.
And barotrauma means that if you are -- for instance, if you're diving or high in a plane and there is a sudden change in pressure, that can

cause swelling of the nose and sinuses, and that is what sometimes patients will complain of when the plane is going up or down and they get like a piercing headache, and that is because there is blockage secondary to the sudden change in pressure.
Q. What are the symptoms of sinusitis, Doctor? Well, I have another chart.
A. Sure. Some of the symptoms here are postnasal drip. If you have pus or secretions in your nose, all of a sudden they start dripping back and the patient will complain of having something sticking in the throat. Sometimes it is this yellow or green stuff. That is postnasal drip.
Nasal congestion or complaints is a common complaint. You say, Doctor, I can't breathe. My nose doesn't work. That is very typical. Why? Because there is inflammation or infection, and that will cause the inside of the nose to be swollen and shuts down the breathing.
Headaches is also a very, very common complaint. The patients usually complain of pressure of headaches here. It hurts between the eyes versus they have something non-related to sinusitis. They say it hurts in the back of the

head or it is in the general area of the sinus.
The purulent nasal discharge is really one of the keys through the endoscope of the nose and you see there is pus.
Q. That's what I was going to say. You said purulent nasal discharge is the key.
What is that?
A. Basically pus coming out of your nose. It means the mucus, instead of being clear, is yellow or green. It is not a color to have in your sinus. So the doctor examines it with an endoscope, and he will see this yellow /green stuff coming from the sinuses, which the reason it is green is because there is bacteria growing in there, and that is the way the pus is.
Q. Purulent nasal discharge isn't clear, it is colored?
A. It is colored, yes.
Q. And the last we have is facial pressure, fever, halitosis, and loss of smell.
A. Facial pressure goes along with a headache because you have -- the sinuses are a rigid structure.
Q. Rigid?
A. Yes. When you have a lot of fluid in

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

there, and the fluid is starting to expand, the sinuses will expand, and that is why the patient says my cheek hurts or nose hurts on the side. It is accumulated there and doesn't have anywhere to go.

Fever you can see in any infection.

Halitosis means bad breath, and you can understand if you have an infection in the nose, you know, and you have pus, that can cause bad breath.

The loss of smell, we have tiny fibers inside of the nose that are nerve endings that allow us to smell perfume, but when there is swelling or infection, the air cannot reach up high in the nose where the fibers are and the patient will say I cannot smell anything.

Q.. Okay. I want to talk -- I think maybe you can take the stand again.

I want to have you tell us, Doctor, if you have a few minutes, how you treat chronic sinusitis.

A. Well, the first thing you do when you see the patient is take a history, a history of the chief complaint, present illness, past history, and you want to know if the patient has been treated by

another physician in the past and what kind of medications they received.

You want to know is this the first time the patient is seeking advice about a sinusitis condition.

Once you have the history, you examine the patient and you always do an endoscopic exam, which I described before. You want to look up into the nose and determine what is the status of the openings of the sinuses into the nose.

If you establish from the history and physical exam that you are dealing with a patient with chronic sinusitis, then you treat them with a broad-spectrum antibiotic. It means a very potent one that will cover a host of bacterias that we know are the most common ones that will cause sinusitis, chronic sinusitis.

And then you treat them at least for three or even up to four weeks. Before we used to think that 10 days was enough or 14 days was enough, but the research shows that you really have to go beyond that.

Once you have treated the patient with antibiotics, then you usually have a medication, such as an antihistamine, or maybe the doctor

thinks the patient has an allergy also, and sometimes you will add some nasal sprays and antiallergic nasal sprays usually based on the steroids to try to improve the drainage of the sinuses into the nose.

Once the patient has completed the treatment, we order a CAT scan, which is an x-ray that we described before, and, at that point, you bring the patient back. You re-examine and take another history, and you ask the patient how is he doing, and you re-examine the patient with an endoscope, and you review the results of the CAT scan to determine if the patient has or has not responded to the medical therapy.

Sometimes you have to repeat the same therapy a second time around and perform another CAT scan. If the patient really hasn't responded after 12 weeks, then you pretty much know -- and you have the positive CAT scan compatible with sinusitis, at that point, you may think the patient may need surgical intervention.

Q. Okay. On the suspected causes of chronic sinusitis that we have listed here, what would you say are the most common causes of chronic sinusitis?

A. Well, in my experience, if you have a combination of the anatomical problems, the allergies and the bacteria -- those are the common ones.

Q. You mentioned allergies. If you suspect that a patient has allergies, do you recommend testing for allergies?

A. Most definitely. We always inquire about it. Sometimes the patients are referred to my office and have been to an allergist before and the allergy evaluation and treatment hasn't been successful.

We alert the patient or tell them that you probably have a condition that's one of the reasons you have the sinusitis, so we test the patients ourselves in our office or we refer them to an allergist so they can perform the appropriate testing. It is something extremely, extremely important that we need to know, if the patient has any kind of allergic condition.

Q. If the patient says to you, gosh, Doctor, I don't think I have allergies, does that affect whether or not you have them tested if you suspect allergies?

A. No, because if you do the tests, you will

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: http://www.industrydocuments.ucsf.edu/docs/knjl0001

not know for sure. A lot of times the perception of the patient about their condition is not what they have. It is very simple to do allergy tests. You can do a block test or a skin test, and once I explain to them that you may think that, but it is appropriate to rule it out or treat you, they usually go ahead and comply.

Q. In your experience, have you had patients that say, gosh, I am not allergic and you have them tested and you find out after the test that they are allergic to certain things?

A. Yes, many cases of it.

Q. Without testing, is there any way of ruling out allergies?

A. No way.

Q. I want to turn for a moment, Doctor, now and talk about some of the specifics about this particular case, Mrs. French's case, and to do that, I'll move some of this. And we are going to look at some of the medical records.

All right. Before you rendered your opinion in this case about Mrs. French and whether or not her chronic sinusitis was caused by secondhand smoke, did you review certain materials, Dr. Torres?

A. Yes, I did.

Q. And can you tell us with respect to Mrs. French what did you review?

A. I reviewed my own textbooks, articles, medical journals, and I reviewed also my experience of 19 years of --

MR. TROP: Your Honor, I object and move to strike as improper bolstering.

THE COURT: Overruled.

THE WITNESS: I also reviewed my experience as a board certified otolaryngologist in 19 years of experience of seeing and treating a lot of the patients. Like I said before, about 50 percent of my practice or more is created to sinuses, and I also reviewed articles provided by the attorneys of Shook, Hardy & Bacon.

BY MS. TEDDER:

Q. And did you review Mrs. French's medical records?

A. Yes, I did.

Q. I would like to take a moment and talk about those medical records, and I am going to hand you, Doctor, a copy of Defendants' Exhibit 1963, which I think it is about 90 pages of medical

records of Dr. Persky.

I will hand you this, Doctor.

A. Thank you.

Q. And ask you first to take a real quick glance through that for me and tell me if those are the medical records of Dr. Persky that you reviewed in this particular case.

A. Yes, they were.

Q. Okay. Now, from these particular medical records, these are numbered in the bottom right-hand corner beginning 10193570001 through, I think, 90, so we have about 90 pages of exhibits here.

If you look at page 0001, can you tell us, Doctor, what was the earliest indication from these records that Mrs. French had been seen by a physician for sinusitis or anything related to her sinuses?

A. We have a date here of June 26th, 1989.

Q. And, for the jury, we put this up on the screen over here. Is this the same page you are looking at, Doctor?

A. Yes, it is.

Q. Okay. And June 26th, 1989, there has been some testimony that Dr. Persky's associate,

Dr. Pleet, saw Mrs. French on that date, and we have that particular page 0001 up on the screen.

Do you see if we move down to diagnosis on that page, Dr. Torres, Dr. Pleet sees Mrs. French and he lists allergic rhinosinusitis, is that correct, under diagnosis?

A. Yes.

Q. Tell us again what does that mean that he thought was causing Mrs. French's problem on June 26th of 1989.

MR. TROP: I object to the form.

THE COURT: Sustained.

BY MS. TEDDER:

Q. Can you tell us, Doctor, in your opinion, in your experience, what is your understanding of what he thought was causing Mrs. French's problem?

MR. TROP: Same objection.

THE COURT: It is really the same.

BY MS. TEDDER:

Q. He lists allergic rhinosinusitis as the diagnosis.

Can you tell us what that is?

A. That means that he felt that there was an allergy that -- the patient was suffering from an allergy, such as a hay fever, which is a common

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Document from www.industrydocuments.ucsf.edu/docs/knjl0001

one. That was producing inflammation of the -- inside the nose and sinuses.

Q. All right. And what does Dr. Pleet prescribe for Mrs. French on that date according to these records?

A. He prescribed a medication called Seldane, which is an antiallergic medication, and he also prescribed Vananase, which is a nasal spray and which is also prescribed for allergies.

Q. That is what I was going to ask you.

Are both of those medications for allergies?

A. Yes, they are.

Q. And can you determine from this record whether or not Dr. Pleet did any allergy testing on that date?

A. I don't find any reference to any allergy testing done that day.

Q. If you turn to page 2 of these records, Dr. Persky's records, there is an entry dated July 26th, 1989.

Do you see that?

A. Yes, I see.

Q. And what does this record reflect happened on that date?

A. Apparently they called a prescription over the telephone. The refill was done of Seldane, Entex, Ceftin.

Q. Are those the refills for medications for allergies?

A. Yes.

Q. And when do the records indicate Dr. Persky first saw Mrs. French?

A. It looks like it was August the 9th of 1989.

Q. Okay. What does the record reflect was his diagnosis on this page, 0002? We have it highlighted there, and it is very hard to read on the copy that is up on the screen, but what was his diagnosis on that date?

A. He wrote chronic sinusitis, allergic rule out anatomical causes.

Q. And what does allergic anatomical causes mean?

A. He felt that the diagnosis was -- he felt there was an allergy problem, but that perhaps it was also some kind of anatomical obstruction, such as we before described, concha bullosa or deviated septum, or so forth, that could be causing the symptoms.

Q. So now Dr. Pleet and Dr. Persky suspect that, in part, there is an allergic component to her problems?

MR. TROP: Judge, objection to the question again.

THE COURT: Because it calls for what the other doctor said?

MR. TROP: Yes.

THE COURT: Sustained.

BY MS. TEDDER:

Q. As reflected on these records and based on the medications they prescribed, do you understand that they felt there was an allergic component to her condition?

A. Yes.

MR. TROP: Same objection.

THE COURT: It is the same question. You can ask what the medications are prescribed for.

MR. TROP: And move to strike.

THE COURT: Granted.

BY MS. TEDDER:

Q. Dr. Torres, would it surprise you that if a patient came in presenting with what is described here that you would be suspicious of an allergic

component to a problem?

A. Yes.

Q. It would surprise you?

A. No. I mean, I think that they are thinking the patient has an allergy.

Q. And in your experience, is that common?

A. Very common.

Q. Okay. And, again, from the records that we just looked at so far, can you tell whether Dr. Pleet or Dr. Persky did anything to rule out allergies as a cause?

A. Nothing was done.

Q. And what could they have done in August of 1989 to rule out allergies?

A. Well, they could have done an allergy test, which is called a skin test, which is commonly performed, or they could have done a Rast test, which is really a block test where you get a blood sample and you send it to the lab and they will determine if the patient has any allergies, or they could refer the patient to an allergist who can do the allergy tests for them.

Q. Is that things you do in your practice?

A. Yes.

Q. Okay. And do you see the diagnosis here

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

of chronic sinusitis by Dr. Persky on August 9th of'89. Do you share that opinion?
A. No.
Q. And can you tell us why not?
A. Well, number one, you don't have an endoscopic examination to support that statement. You don't have a CAT scan to support that statement, and you don't have the adequate time of treatment to support that statement as well.
Q. And when you say adequate time of treatment, are you talking about symptoms that lasts more than 12 weeks in duration?
A. Correct.
Q. Okay. In your opinion, it was premature to diagnose Mrs. French with chronic sinusitis on this date?
A. I think it was premature.
Q. What would your diagnosis have been on August 9th, 1989?
A. Probably I would be thinking that the patient had an allergy and acute sinusitis.
Q. If we look a little bit further down on that page, we can see an entry dated 8-25-89.
A. Yes.
Q. See that?

A. Yes, I see it.
Q. All right. And, again, the prescription there is for Seldane and --
A. Entex.
Q. And are both of those medicines prescribed for allergies?
A. Yes, they are.
Q. If we look a little bit further down on that same page to the entry 9-5-89, that says scheduled for CT scan.
Do you see that?
A. Yes, I see it.
Q. Okay. Why would you schedule a patient for a CT scan?
A. You want to find out information about what is the status of the sinuses.
Q. And without a CT scan, can you determine whether -- can a doctor determine whether the condition that he sees is an acute or a chronic sinusitis?
A. No.
Q. Okay. And, again, can you tell from your review of these records whether Dr. Persky ever examined Mrs. French with an endoscope?
A. I could not find any evidence that he was

using an endoscope.
Q. Not just on the dates we were looking at, but from these records at all?
A. Correct.
Q. All right. Let's take a look if you can turn to page 30 of these records, I think, 00030 at the bottom of the page. We'll put that one up for the jury to take a look at so they can follow along with you, Dr. Torres.
This is dated 9-7-89, and this is the result of her 1989 CT scan, correct?
A. Correct.
Q. Okay. And can you tell us, Doctor, the second paragraph of this reads there are large air fluid levels seen in the maxillary antra. Small air fluid levels are seen in the ethmoid sinuses. No air fluid levels are identified in the frontal sinuses or the splenoid sinuses. There is mild mucosal thickening. No definite retention cysts are seen. No thinning or ballooning or sequestra or bone destruction is seen.
Can you tell us what this report tells you about whether or not Mrs. French's sinusitis in 1989 was chronic or acute?
A. This is a typical x-ray of an acute

sinusitis.
Q. And what is there about this that tells you that?
A. That the patient had air fluid levels inside of the sinuses.
Q. So the large air fluid levels is consistent with--
A. Acute sinusitis.
Q. Okay. Is surgery normally necessary to resolve acute sinusitis?
A. No, it is not.
Q. And why not?
A. Because the vast majority of the patients will respond to appropriate medical therapy if you give the right antibiotic for the appropriate length of time.
Q. And we already know from the records in this case that Dr. Persky did, in fact, perform surgery on Mrs. French on about September 20th, 1989, so if we turn to the operative report for that date, which I think is page 000033 of these records, and if we can put that operative report up for the jury to follow along with. That is dated 9-20-89. It lists the surgeon as Dr. Michael Persky.

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001

If we take a look at this operative report, Doctor, what is the significance of this operative report to you?

If you can tell us what you are looking at when you turn to it, on which page.

A. I am looking at page 34.

Q. All right. 2 of the operative report?

A. Yes.

Q. And what is significant to you in this report?

A. Well, if you look at the paragraph that starts there was no fluid in the maxillary sinus --

Q. And that's the third full paragraph on that page?

A. Yes. And he describes that the endoscope was then placed through the natural ostia into the sinus and the sinus was observed to have normal mucosa, so, in other words, he went and did the operation, but he found no evidence of sinusitis, whatsoever, and the best way to determine the status of the sinus, even better than a CAT scan, is if you actually are able to look in there, so he found that there was no evidence of chronic or acute sinusitis for that matter.

Q. Okay. So you are saying he found no

evidence of sinusitis at all?

A. Correct.

Q. Well, if Mrs. French did not have sinusitis when the surgery was performed, what does that tell you about what type of sinusitis, if any, she had before the surgery?

A. That she had an acute sinusitis and that it cleared up by the time the surgery was done.

Q. Doctor, have you ever heard of an acute sinusitis superimposed on a chronic sinusitis?

Is that a term that makes any sense to you?

A. Not really.

Q. Is that how you would characterize this report?

What was going -- that is not how you would characterize what was going on at the time of this operation in September of 1989, correct?

A. No.

Q. All right. At the time of this operation, there was also a pathology report that was generated from some of the tissue, and I think that if we take a look at this record and put it up for the jury, it is page 0029. It is dated September 20th, 1989. Dr. Persky testified this is

the pathology report from that surgery. Let's put this up, and I think, Barb, if you will highlight just what it says under final diagnosis there in yellow, the jury might be able to read it.

It is a little bit difficult, but, Dr. Torres, can you tell us what that says under final diagnosis?

A. It says maxillary ethmoid sinus showing numerous portions of subacute chronically inflamed respiratory epithelial lined mucosa without granuloma or tumor.

Q. There are a lot of big words there, but before we talk about the pathology, can you tell me, Doctor, do ENTs make a diagnosis of what they see as an acute sinusitis or chronic sinusitis based on the pathology report like we have here on page 29?

A. No, we don't.

Q. Okay. And why not?

A. Well, the established criteria -- and this was done around 1997 with a big world symposium. It is basically the patient's original symptoms and CAT scan results, but it is not used because they are -- they don't help us in any way.

Q. You told me before that in addition to

the CT scan, you know, you give a patient medical treatment over time and you prescribe medication and you kind of take all of those things into account before you make a diagnosis; is that correct?

A. Correct.

Q. And the pathologist, now he's not there when you treat the patient on a day-to-day basis, is he?

A. He is never there.

Q. Would he know the history of the patient?

A. No.

Q. What is his role in this?

A. His role is to take a look at the tissue that is sent from the operating room and they usually see it one or two days later.

Q. One of the things you told me just a little bit ago was that you could determine that Mrs. French previously had large air fluid levels which you said was a mark of acute sinusitis.

Would the pathologist know about that?

A. Usually they don't.

Q. Okay. What does the term "clinical diagnosis" mean, Doctor?

A. Clinical diagnosis means after you take a

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Source: http://www.industrydocuments.ucsf.edu/docs/knjl0001

complete history from the patient and you examine the patient, you form an opinion of what kind of disease the patient has.

Q. And is chronic sinusitis a clinical diagnosis or a pathologic diagnosis?

THE COURT: Or a what?

BY MS. TEDDER:

Q. Pathologic diagnosis.

A. It is a clinical diagnosis.

Q. It is not one that the pathologist makes, correct?

A. Correct.

Q. All right. Now, turning to this pathology report, Doctor, and the language that is listed here, what does this pathology report tell you?

A. That the patient had an acute sinusitis.

Q. Okay. And the pathologist mentions -- well, strike that. Let me just ask you, can you tell from this pathology report where in the sinuses the tissue that he looked at comes from?

A. Not really. I mean, everything was sent in one specimen labeled maxillary ethmoid. You don't know if it came from the right or the left or it came from the ethmoid and part from the

maxillary, so you don't know where it came from.

Q. Okay. He mentions chronically inflamed respiratory epithelial lined mucosa without granuloma or tumor.

Is there any way the pathologist can tell from the tissue how old the inflammation is?

A. No.

Q. Doctor, what is your final diagnosis of Mrs. French's condition in September of 1989?

A. That the patient had an acute sinusitis and she most likely had allergies.

Q. We know Mrs. French continued to see Dr. Persky periodically after 1989, and I would like to take a look at some of those records, and if we turn to page -- back up to page 3 of Defendants' Exhibit 1963, we see several entries, and let me see if I can guide you where I am looking at, Doctor.

We see several entries that begin the middle of the page from about 9-25-89. There are three or four entries that continue on that page and entries that continue up to about the end of October of 1989 on the next page.

Do you see those approximately five entries?

A. Yes.

Q. You've reviewed these entries, correct?

A. Yes.

Q. And can you tell from these entries how did Mrs. French get along immediately after her sinus surgery?

A. It looks like she was doing well after -- initially after the surgery.

Q. Okay. After a surgery, what kind of a follow-up would you expect to see postoperatively in a patient who had just had sinus surgery?

A. Well, we see them on a regular basis. Sometimes we just do packing and sometimes we don't, and we usually do it between the third or fifth day.

After that we do an endoscopic examination of the patient, and we are careful to suction secretions from the area of the surgery, any blood or mucus that still may be accumulated in there, and we instruct them to do nasal irrigations, and we keep them on antibiotics also right after the surgery for a longer time. And, at that point, we restart the antiallergic medications into the patient.

We also give them nasal steroidal sprays

so that we shrink the inside of the mucosa and the sinuses will continue to drain properly, so you need to do sometimes what we call a debridement, which is a procedure that we use an endoscope and some instruments to go into the area that you did the surgery to kind of clean and keep that area open.

Q. Okay. During any of these post-op visits that we are looking at, did Dr. Persky examine Mrs. French with an endoscope?

A. I cannot find evidence of that.

Q. Why would it be important to examine a patient with an endoscope at this time?

A. Because that is the only way you can assess how the healing process is taking place after the operation, and with an endoscope, you can, like I said before, do some cleaning or debridement that will help the patient to feel better.

Q. Okay. And without an endoscope, is there any way to determine -- well, let me ask you first can scar tissue develop after a surgery?

A. Yes, it can.

Q. Is that a normal complication?

A. Well, it doesn't happen to everybody, but

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by the UCSF Industry Documents Library. http://www.industrydocuments.ucsf.edu/docs/knjl0001

probably around 10 or 20 percent of the patients that have this kind of surgery.

Q. And when you look at a patient with an endoscope, is that one of the things you are checking for?

A. Yes.

Q. To see if there are scar tissue levels?

A. Yes.

Q. Is there a way to do surgery without scarring?

A. During the time you are doing the surgery, you have to be very gentle. When you put the endoscope inside of the nose, you need to be very gentle, and you use small instruments to open the areas so that you don't get a lot of rough surfaces to form a scar, and also we put in spacers which are like little devices made of foam or different material so that the sinuses stay open, so there are different techniques that we use to avoid that problem.

Q. What would you look for postoperatively in terms of scarring?

A. Well, I want to know if the scarring is making the middle turbinate, which is an area I drew before, laterally displaced and close the

ostium we have described.

Q. And how do you find out if you left a scar?

A. By doing an endoscopic exam.

Q. If the scar developed, what would a doctor do?

A. Well, if the patient was having symptoms and problems, you would do a cut of the scar. Sometimes you can actually do it in the office very simply with an instrument and you put a spacer in or sometimes you put a patient for a short procedure in the operating room where you go in there and you cut the scar and whatever scar may be there and you start in that range.

Q. Why would it be important after surgery if there were scarring to address that?

A. Because one of the reasons why this endoscopic sinus surgery -- to see if the patient has scarring which would compromise the drainage.

Q. The scarring can compromise the drainage in the ostia?

A. Yes.

Q. Did you see any indication in those records that the kind of follow-up that you've just described for me happened in this particular case?

A. No, I did not.

Q. If we take a look at the medical records, Doctor, and we take a look at pages 4 and 5, those outline occasional visits Mrs. French had over the next four to five years, is that correct, four, five and six maybe?

A. Yes.

Q. And can you tell us with respect -- I think you said Mrs. French did relatively well over the next four to five years.

A. Yes.

Q. Okay. Relatively symptom free for sinus problems?

A. Yes.

Q. Let's take a look at just a couple of these records.

There is an entry dated October 2nd, 1990. This appears to be the one and only visit Mrs. French had in 1990 and is about a little over a year after the surgery.

The diagnosis listed there or, I mean, this indicates that Mrs. French, if I am reading this correctly, had a cold; is that correct?

A. Correct.

Q. Is there any indication in this record,

in Dr. Persky's records, that Mrs. French's cold was somehow related to sinusitis?

A. No.

Q. And it would appear then from the records that Mrs. French goes about six months before her next visit on April 2nd of 1991, and do you see that in the middle of that page?

A. Correct.

Q. And this says a couple of things that are a little bit difficult to read, but it says physical exam, PE. is that what that means, physical exam?

A. Yes.

Q. It says clear rhinorrhea?

A. Yes.

Q. And what is Dr. Persky's assessment of Mrs. French's condition on that date? A, what does that say?

A. Rhinosinusitis.

Q. And would you agree with that assessment?

A. Well, usually when you have a rhinosinusitis or the rhinorrhea, the mucus coming from the nose is the green or yellow.

Q. The purulent discharge you told us about earlier?

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

A. Yes.
Q. This says clear rhinorrhea. What is clear rhinorrhea a symptom of?
A. It's usually seen in allergies where you get the clear mucus coming from your nose which is not infected.
Q. And let's take a look at another of these entries. For example, the bottom of that page, it looks like December 31st.
A. Yes.
Q. Do you see that, the assessment? Take a look at that. Can you read his assessment on that date?
A. He wrote sinusitis/OM, which usually stands for otitis media, which is an infection of the middle ear.
Q. And are the symptoms that he outlines on that date consistent with sinusitis?
A. Well, from the physical exam, it looks like he basically examined the ears only on the PE. it just says the ears.
Q. Would you agree with his assessment on that date then?
A. Well, I would probably agree with the otitis media, but if you don't examine the nose, it

is hard to figure out how you make a diagnosis of sinusitis.
Q. Let's take a look at the next page, 0005, of the records, and I will direct your attention to an entry dated October 8th of '93. Do you see that in the middle of the page?
A. Yes.
Q. And, again, the assessment -- let me see if I see it. The assessment on that page, can you read that for us under A?
A. OM, which stands for otitis media or infection of the ear/sinusitis.
Q. Okay. And I also see in the line right two above that, and it is very hard to read, but does that say nose congested, clear discharge?
A. Yes.
Q. Okay. And, again, what is the clear discharge symptomatic of?
A. Well, it is more typical of an allergy. It is not typical of any kind of sinusitis.
Q. Would you disagree with his assessment on that date of sinusitis?
A. Yes, I would.
Q. Okay. Can you tell just from your review of these records over the next couple of pages does

Dr. Persky give -- continue to give Mrs. French antibiotics over this time period?
A. Yes, it looks like a lot of antibiotics were given over the phone without the patient receiving a physical examination.
Q. And antibiotics are often prescribed for bacterial infections; is that correct?
A. Correct.
Q. And, in your opinion, does Mrs. French, the first couple of years after this surgery, have chronic sinusitis during that period?
A. No.
Q. At some point, in your opinion, did Mrs. French develop chronic sinusitis?
A. Yes.
Q. And can you tell us when?
A. Well, the first time we have actually any kind of medical diagnosis or CAT scan is done in 1995, and, at that point, the CAT scan showed a thickening, which is one of the findings in chronic sinusitis, so my opinion is that it was most likely at that time.
Q. Let's take a look at page -- I will direct your attention, Doctor, and if you can put up for the jury page 00031 of Defendants' Exhibit

1963. This is the 1995 CT scan dated August 31st of 1995. We are putting this up for the jury to take a look at, Doctor.
I would ask you to take a brief minute just to review that.
MR. TROP: Your Honor, may we have a very brief side-bar? We don't even need the court reporter.
(Whereupon, a bench conference was had)
MR. TROP: Your Honor, can we take a few minutes?
THE COURT: We will have a break for lunch now.
(Whereupon, the proceedings were resumed before the jury)
THE COURT: We have been going quite a while, and since it is after noon, we will break for lunch, so we will start at 1:30. We will resume with the direct testimony of Dr. Torres. Okay.
So please, jurors, enjoy your lunch and report back to where you are supposed to at 1:30.
(Jury absent)

http://legacy.library.ucsf.edu/tid/qrr07a00/pdf Source: https://www.industrydocuments.ucsf.edu/docs/knjl0001

THE COURT: We will resume at 1:30 and finish with Dr. Torres and go to the testimony of Dr. Richmond. Will that be ready?

MS. WEINSTEIN: Hopefully. It is at the Defendants' office, and we will blame them if it is not.

THE COURT: Do you think we will get further than that today?

MR. WEINSTEIN: Through what?

THE COURT: Further than that, any further than that? Does the Defendant have any other witnesses available?

MR. ENGRAM: Your Honor, we do have another witness available. We will make full use of the time available to us, your Honor.

THE COURT: Okay. Who is the other witness so the Plaintiffs know?

MR. ENGRAM: It would be Ron Sands.

THE COURT: Okay. So we will meet at 1:30.

(Whereupon, a luncheon recess was had)

http://legacy.library.ucsf.edu/tid/grr07a00/pdf Support provided by www.industrydocuments.ucsf.edu/docs/knjl0001